DO NOT STAPLE
IN THIS AREA

BlueCross BlueShield of Georgia

PRESCRIPTION DRUG CLAIM

MAIL TO

P.O. BOX 9907
Columbus, Georgia
31908-6007

SUBSCRIBER'S CONTRACT NUMBER

PLEASE REVIEW THE INFORMATION CONTAINED ON THE REVERSE OF THIS FORM.
PLEASE PRINT ALL INFORMATION.
USE A SEPARATE CLAIM FORM FOR EACH MEMBER.

SUBSCRIBER MUST COMPLETE THIS SECTION.

SUBSCRIBER'S NAME (LAST, FIRST, MI)	GROUP NUMBER	PRESCRIPTIONS WERE DISPENSED TO: PATIENT'S NAME (LAST, FIRST, MI)	
SUBSCRIBER'S STREET ADDRESS	DAYTIME TELEPHONE NUMBER	PATIENT'S BIRTHDATE	SEX ☐ MALE ☐ FEMALE
CITY STATE ZIP CODE		RELATIONSHIP TO SUBSCRIBER (CHECK ONE) ☐ SELF ☐ SPOUSE ☐ CHILD ☐ STEPCHILD ☐ OTHER CHILD	

MEDICAL INFORMATION

DESCRIBE THE ILLNESS OR INJURY WHICH REQUIRED TREATMENT			
	IF INJURY, GIVE DATE OF ACCIDENT	MO DAY YR	WAS CONDITION EMPLOYMENT RELATED? ☐ YES ☐ NO

OTHER COVERAGE INFORMATION

IS THE PATIENT COVERED BY ANOTHER GROUP HEALTH INSURANCE PLAN INCLUDING ANOTHER BLUE CROSS/BLUE SHIELD PLAN? ☐ YES ☐ NO	IF "YES" COMPLETE THE FOLLOWING	IS THE OTHER COVERAGE: ☐ BLUE CROSS/BLUE SHIELD ☐ OTHER MEDICAL & DRUG		
POLICYHOLDER'S NAME	RELATIONSHIP TO PATIENT	POLICYHOLDER'S EMPLOYER		
INSURANCE COMPANY'S NAME	POLICY NUMBER	GROUP NUMBER	EFFECTIVE DATE	BIRTHDATE
INSURANCE COMPANY'S STREET ADDRESS	CITY	STATE	ZIP CODE	

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.	SIGNATURE OF PATIENT/OR PARENT IF MINOR	DATE

PLEASE HAVE YOUR PHARMACIST COMPLETE THIS SECTION: WE CANNOT PROCESS THIS FORM WITHOUT THIS INFORMATION
PRESCRIPTIONS FILLED ON OR AFTER JANUARY 1, 1992 SHOULD BE SUBMITTED ON THIS CLAIM FORM.

RX NUMBER	DATE FILLED	CHECK ONE (Optional)	METRIC QUANTITY	DAYS SUPPLY	PRESCRIBER NAME OR I.D. # (Optional)	IS RX BRAND NECESSARY
	M / D / Y	NEW RX ☐ 0 REFILL RX ☐ 1				NO ☐ 0 / YES ☐ 1 OR Patient DAW ☐ 2 / RPh DAW ☐ 3 / No Generic ☐ 4
REFERENCE NUMBER	MEDICATION NAME	IS DRUG (Optional) COMPOUND RX ☐ 1 ALLERGY INJ. ☐ 2	NDC NUMBER			RX PRICE $
RX NUMBER	DATE FILLED	CHECK ONE (Optional)	METRIC QUANTITY	DAYS SUPPLY	PRESCRIBER NAME OR I.D. # (Optional)	IS RX BRAND NECESSARY
	M / D / Y	NEW RX ☐ 0 REFILL RX ☐ 1				NO ☐ 0 / YES ☐ 1 OR Patient DAW ☐ 2 / RPh DAW ☐ 3 / No Generic ☐ 4
REFERENCE NUMBER	MEDICATION NAME	IS DRUG (Optional) COMPOUND RX ☐ 1 ALLERGY INJ. ☐ 2	NDC NUMBER			RX PRICE $
RX NUMBER	DATE FILLED	CHECK ONE (Optional)	METRIC QUANTITY	DAYS SUPPLY	PRESCRIBER NAME OR I.D. # (Optional)	IS RX BRAND NECESSARY
	M / D / Y	NEW RX ☐ 0 REFILL RX ☐ 1				NO ☐ 0 / YES ☐ 1 OR Patient DAW ☐ 2 / RPh DAW ☐ 3 / No Generic ☐ 4
REFERENCE NUMBER	MEDICATION NAME	IS DRUG (Optional) COMPOUND RX ☐ 1 ALLERGY INJ. ☐ 2	NDC NUMBER			RX PRICE $
RX NUMBER	DATE FILLED	CHECK ONE (Optional)	METRIC QUANTITY	DAYS SUPPLY	PRESCRIBER NAME OR I.D. # (Optional)	IS RX BRAND NECESSARY
	M / D / Y	NEW RX ☐ 0 REFILL RX ☐ 1				NO ☐ 0 / YES ☐ 1 OR Patient DAW ☐ 2 / RPh DAW ☐ 3 / No Generic ☐ 4
REFERENCE NUMBER	MEDICATION NAME	IS DRUG (Optional) COMPOUND RX ☐ 1 ALLERGY INJ. ☐ 2	NDC NUMBER			RX PRICE $

PHARMACIST/DISPENSING PHYSICIAN MUST COMPLETE:

PHARMACY NAME/DISPENSING PHYSICIAN	
STREET ADDRESS CITY STATE ZIP CODE	

PHARMACY NABP NUMBER
SEE REVERSE SIDE FOR NABP NUMBER INSTRUCTIONS
IF DISPENSED BY PHYSICIAN USE ALL 9 SPACES FOR TIN NUMBER

TOTAL PRICE $

SIGNATURE OF PHARMACIST/DISPENSING PHYSICIAN	DATE

I N S T R U C T I O N S

Please read this carefully before completing the claim form. **Claim forms without the required information cannot be processed. Incomplete claim forms will be returned to you.**

EMPLOYEE:

a. Take this claim form **to the pharmacy** when you obtain prescription drugs.

b. Use a separate claim form for each patient.

c. If you use more than one pharmacy, use separate claim forms for each pharmacy.

d. You must complete the top portion of the claim form (Social Security number, name, address, etc.) before presenting it to the pharmacist.

e. Give the claim form **to your pharmacist** to complete the lower portion (Rx number, drug dispensed, etc.)

f. A cash register tape is not considered satisfactory evidence of purchase.

g. A computer printout of the prescription from the pharmacy cannot be processed. This claim form must be completed on the reverse side. Your pharmacist may complete a Prescription Drug Universal Claim Form (UCF) and attach it to this form instead of completing the lower portion of this claim form.

h. **Prescriptions filled on or after January 1, 1992 should be submitted on this claim form.**

i. Mail Prescription Drug Claim Forms directly to:

BLUE CROSS AND BLUE SHIELD OF GEORGIA
P.O. BOX 9907
COLUMBUS, GEORGIA 31908-6007

IF YOU NEED INFORMATION ABOUT COMPLETING THIS FORM OR CLAIMS ASSISTANCE IN GENERAL, PLEASE FEEL FREE TO CALL OUR CUSTOMER SERVICE DEPARTMENT.

ATLANTA CALLING AREA	(404) 233-1649
COLUMBUS CALLING AREA	(706) 571-0230
ALL OTHER AREAS	800-441-2273

REMEMBER: The Social Security number and patient information must be valid and correct. The pharmacist must complete the lower portion of the claim form.

PHARMACY INSTRUCTIONS

PHARMACIST: TO PREVENT DELAY OF YOUR CUSTOMER'S CLAIM:

Upon availability, when using a Pharmacy computer or POS device:
a. You need to record only the claim reference number and your signature onto the claim form.
b. Do not include both reference number and non-reference number items on the same claim form. Claims that could not be placed on the POS system should be entered on a separate Prescription Drug Claim form.

If you are not using a Pharmacy computer or POS device:
a. Complete the lower portion in detail (Rx number, drug dispensed, etc.) if you do not have any approved POS device for validating member eligibility.
b. You must provide the complete name and address of the pharmacy, NABP number, and authorized signature. The first six digits of your seven digit NABP number is the same as the provider number used for many other pharmaceutical administrators.
c. You may complete a Universal Claim Form (UCF) instead of completing the lower portion of this claim form. THE UCF MUST BE ATTACHED TO THIS CLAIM FORM AND BE SUBMITTED BY THE SUBSCRIBER. The pharmacy NABP number must be written on the front of the claim form or on the Universal Claim Form. Do not attach more than 4 prescriptions per Prescription Drug Claim form.

TO THE PHARMACIST - IF YOU HAVE QUESTIONS CALL:

Atlanta Calling Area	(404) 233-2302
Columbus Calling Area	(706) 571-0932
All Other Areas	800-241-7475